STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 01 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 12/12/11 Facility Number: 000305 Provider Number: 155625 AIM Number: 100287200 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Arbor Grove Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 89 and had a census of 67 at the time of this visit.	K0000	The creation and submission of this plan of correction does not consitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 12/15/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 6 of 107 corridor doors would latch and resist the passage of smoke with no impediment to closing the doors. This deficient practice affects two residents in each resident room numbers 304, 311, 404, 405, 407 and 409. Findings include: Based on observations on 12/12/11 during a tour of the facility from 9:10 a.m. to	K0018	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.The door hardware and frames were adjusted to assure proper latching and closing for all residents affected by alleged deficient practice.II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.Monthly fire drills will be conducted where all resident room doors will be closed and	01/11/2012

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	1:40 p.m. with the maintenance supervisor, the room doors to resident room 410, resident room 409, resident room 407, resident room 405, resident room 404, resident room 414, resident room 304, and resident room 311 each had between a one inch and two inch gap along the top and latching sides of the doors. Furthermore, the room doors to resident rooms 409, 407, and 304 failed to latch into the door frame. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the 1:45 p.m. exit conference on 12/12/11.		monitored for proper latching during the fire drill. III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.Staff will monitor for proper closing and latching of resident room doors during monthly fire drills.IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.The Maintenance Director will review monthly for compliance. Executive Director will review monthly for 3 months and then quarterly for 2 quarters.	
K0025 SS=E	3.1-19(b) Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 1. Based on observations and interview, the facility failed to ensure 4 of 7 attic smoke barriers were constructed to provide at least a one half hour fire resistance rating. This deficient practice affects all residents in the facility.	K0025	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.The attic smoke barriers which were allegedly deficient were repaired and corrected to a rated assembly to meet correct code.II. How other residents	01/11/2012

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	Findings include: Based on observations with the maintenance supervisor on 12/12/11 during observation of the attic smoke barriers from 1:10 p.m. to 1:35 p.m., the following attic smoke barrier walls above smoke barrier doors had penetrations with no fire stopping material: a. The 300 Hall smoke barrier wall had six, two inch to four inch gaps around sprinkler piping penetrations with no fire stopping material. b. The 400 West Hall smoke barrier wall had five, two inch to four inch gaps around sprinkler piping and electrical conduit penetrations with no fire stopping material. c. The 400 Center Hall smoke barrier wall had three, one inch to three inch gaps around sprinkler piping and electrical conduit penetrations with no fire stopping material. d. The 400 Hall end hall smoke barrier had a twelve inch gap around a water pipe main line with no fire stopping material. The attic smoke barrier penetrations not fire stopped was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the 1:45 p.m. exit conference on 12/12/11. 3.1-19(b)		having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.All residents were identified as being potentially affected by the alleged deficient practice. The attic smoke barriers which were allegedly deficient were repaired and corrected to a rated assembly to meet correct code.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.Smoke barriers will be added to the preventative maintenance log for monitoring of proper construction quarterly for 4 quarters.IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.This will be reviewed by the Quality Assurance team quarterly for 1 quarter and then annually for 1 year.	

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	2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barrier was continuous through all concealed spaces including interstitial spaces. 8.3.2 states smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. This deficient practice could affect any residents who use the main dining room, located adjacent to the kitchen food storage room. Findings include: Based on observation with the maintenance supervisor during a tour of the facility from 9:10 a.m. to 1:40 p.m. on 12/12/11, the kitchen attic access panel located in the kitchen food storage room was a sheet of non rated plywood with a non rated Formica cover. Furthermore, the Service Hall attic access panel in the Service Hall storage room had a four inch by twelve inch section of the attic access panel missing between the food storage room and the attic space above. This was verified by the maintenance supervisor at			

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	the time of observations and confirmed by the administrator at the 1:45 p.m. exit conference on 12/12/11. 3.1-19(b)			
K0027 SS=E	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 3 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 30 residents who reside on the 400 Hall, and 20 residents who reside on the 100 Hall. Findings include: Based on observations with the maintenance supervisor during a tour of	K0027	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.The coordinators on the smoke barrier doors were adjusted to allow proper closing so that the doors would close completely without gaps.II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.Residents residing on the 400 and 100 halls were identified as having the potential to be affected due to the proximity of their rooms to the smoke barrier doors. The coordinators of those smoke barrier doors were adjusted so that the alleged deficient practice was corrected.III. What measures will be put into place or	01/11/2012

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	the facility after the fire alarm system was tested on 12/12/11 at 1:10 p.m., the 400 West Hall set of smoke barrier doors, the 400 Hall set of smoke barrier doors, and the 100 Hall set of smoke barrier doors next to the Rehabilitation Hall did not close completely, leaving between a six inch gap and a twelve inch gap between the doors where the door coordinators failed to function. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the 1:45 p.m. exit conference on 12/12/11.		what systemic changes will be made to ensure that the deficient practice does not recur.Smoke barrier doors will be reviewed for proper operation monthly during the fire drill.IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.The Quality Assurance team will review quarterly for 1 quarter and annually for one year to monitor for compliance.	
K0029 SS=E	3.1-19(b) One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor doors to 3 of 14 hazardous areas, such as combustible storage rooms over 50 square feet, and a laundry room over 100 square feet, were provided with self closing devices which would cause the doors to automatically close and latch into the door	K0029	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.Self closing devices were installed and/or adjusted for proper closing on the corridor doors in the areas affected by the allegedly deficient practice.II. How other residents having the	01/11/2012

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	frames. This deficient practice could affect 22 residents who reside on the 200 Hall. Findings include: Based on observations on 12/12/11 during a tour of the facility from 9:10 a.m. to 1:40 p.m. with the maintenance supervisor, the Service Hall storage room, which measured three hundred sixty square feet, the four hundred twelve square foot laundry room north door, and the 200 Hall storage room, which measured eighty square feet, each lacked a self closing device on the room doors. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the 1:45 p.m. exit conference on 12/12/11. 3.1-19(b)		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.Residents residing on a wing with a combustible storeage area located on that wing were identified as having the potential to be affected by the alleged deficient practice. Areas defined according to code as being a possible combustible storeage room had self closing devices installed and/or adjusted for proper closing on the corridor doors.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.Monitoring of proper closing devices to meet code will be added to the preventative maintenance log to be reviewed quarterly for 4 quarters.IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.The proper closing devices on the preventative maintenance log will be reviewed by the Quality Assurance Team quarterly for 1 quarter and annually for 1 year.	

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K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on interview and record review, the facility failed to conduct quarterly fire drills on 1 of 3 shifts for 2 of 4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on review of Monthly Fire Drill Reports with the maintenance supervisor on 12/12/11 at 9:15 a.m., a fire drill was not documented for the third shifts of the first quarter (January, February, and March) and second quarter (April, May, and June) of 2011. Additionally, based on interview with the maintenance supervisor during the review of the Monthly Fire Drill Reports, there was no other documentation available for review to verify these drills were conducted. 3.1-19(b) 3.1-51(c)	K0050	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.Fire drills will be completed in accordance with life safety code. A Maintenance designee has also been assigned to complete and monitor the duties of the Maintenance Supervisor such as fire drills in the absence of that position.II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.All residents had the potential of being affected but were not harmed by the alleged deficient practice. Fire drills will be completed in accordance with life safety code. A Maintenance designee has also been assigned to complete and monitor the duties of the Maintenance Supervisor such as fire drills in the absence of that position.III. What measures will be put into place or what systemic changes will be made to ensure that the	01/11/2012

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			deficient practice does not recur.A maintenance supervisor designee has been assigned and trained to perform certain necessary duties that cannot be contracted out for completion such as fire drills in the absence of the maintenance supervisor position. Fire drills will be reviewed by the Executive Director monthly times 3 months and quarterly for 2 quarters.IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.Compliance will be monitored monthly by the Executive Director for 3 months and quarterly for 2 quarters.	
K0052 SS=F	A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to provide annunciation for 1 of 1 fire alarm systems in an area where it would be heard anytime in accordance with NFPA 72. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and	K0052	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.A remote annunciator for the fire alarm system is installed in the 400 hall nurses station. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.All residents had the potential to be affected by the alleged deficient	01/11/2012

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	descriptively annunciated. This deficient practice could affect all residents in the facility. Findings include: Based on observation on 12/12/11 during a test of the fire alarm system with the maintenance supervisor at 1:10 p.m., the fire alarm control panel (FACP) was located in the 400 Hall mechanical room, an area remote from any area where continuous on site monitoring could occur, such as the nurses' station. Furthermore, the only fire alarm system annunciator in the facility was located in the Administration Hall pantry, which was enclosed by a door and was not visible or audible from a nurses' station. The lack of fire alarm system annunciation was verified by the maintenance supervisor at the time of fire alarm system testing and confirmed by the administrator at the 1:45 p.m. exit conference. 3.1-19(b)		practice. A remote annunciator for the fire alarm system is installed in the 400 hall nurses station. III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.A remote annunciator for the fire alarm system is installed in the 400 hall nurses station. This will correct the alleged deficient practice with no reoccurrence. The proper functioning of the remote annunciator for he fire alarm system will be tested monthly during fire drills. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The proper functioning of the remote annunciator for he fire alarm system will be tested monthly during fire drills. This will be monitored monthly by the Maintenance Director or designee.	
K0062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure 5 of over 300 sprinkler heads in the facility were	K0062	I. What corrective action(s) will be accomplished for those residents found to have been	01/11/2012

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	maintained. This deficient practice could affect 22 residents who reside on the 300 Hall. Findings include: Based on observations on 12/12/11 during a tour of the facility with the maintenance supervisor from 9:10 a.m. to 1:40 p.m., the two sprinkler head escutcheons in the Service Hall clean linen room, the one sprinkler head escutcheon in the Service Hall communication room, and the one sprinkler head escutcheon in resident room 309 above bed 1, were not flush to the ceiling leaving a one inch to three inch gap into the attic space above. Furthermore, the 300 Hall storage room sprinkler lacked an escutcheon. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the 1:45 p.m. exit conference on 12/12/11. 3.1-19(b)		affected by the deficient practice.The sprinkler escutcheons have been moved up and all gaps appropriately fire stopped.II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.All residents had the potential of being affected by the alleged deficient practice. The sprinkler escutcheons have been moved up and all gaps appropriately fire stopped.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.Compliance wih this life safety code will be monitored quarterly by the contracted sprinkler system company during biannual inspection and testing.IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.The quarterly inspection and testing will be monitored by the Maintenance Supervisor or designed and overseen by the Executive Director or designee.	
K0067 SS=F	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on observation and interview, the facility failed to ensure 7 of 7 egress	K0067	I. What corrective action(s) will be accomplished for those residents found to have been	01/11/2012

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	corridors were not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a potion of a supply return or exhaust air system serving adjoining areas. This deficient practice affects all resident in the facility. Findings include: Based on observations on 12/12/11 during a tour of the facility from 9:10 a.m. to 1:45 p.m. with the maintenance supervisor, all rooms in the facility used the egress corridors as a return air system. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the 1:45 p.m. exit conference on 12/12/11. 3.1-19(b)		affected by the deficient practice.After the actual life safety survey, it was discovered that a system already exists that is in compliance with K067 NFPA 101 Life Safety Code Standard section 9.2. This system is a smoke detecting system within the duct work of the HVAC system. If smoke is detected by the smoke detectors, it sends a signal to the furnace to shut down the air flow and also sets off the fire alarms. The facility submitted an annual waiver on 1/8/12.II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.No residents were affected or had the potential to be affected because a system already existed and was in place to ensure their safety. The facility submitted an annual waiver on 1/8/12.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.The smoke detectors are put through a sensitivity test semiannually. Please see attached. The facility submitted an annual waiver on 1/8/12.IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.Sensitivity testing will continue to be performed and monitored for proper functioning	

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			semiannually. This will be monitored by he Maintenance Supervisor for compliance semiannually. The facility submitted an annual waiver on 1/8/12.	
K0070 SS=E	Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation and interview, the facility failed to provide evidence 2 of 2 portable space heating devices heating elements did not exceed 212 degrees F. This deficient practice could affect 30 residents who reside on the 400 Hall, and any residents who use the Administration Hall lounge. Findings include: Based on observations on 12/12/11 during a tour of the facility from 9:10 a.m. to 1:40 p.m. with the maintenance supervisor, the 400 Hall dining room and the Administration Hall lounge each had a mock fire place in use with an electrically interconnected space heating device in each room. Based on an interview with the maintenance supervisor on 12/12/11 at 10:40 a.m., the mock fire place space heaters are used in these resident areas. The use of portable space heating devices in the 400 Hall dining room and Administration Hall lounge, which were resident use areas, was confirmed by the administrator at the 1:45 p.m. exit conference on 12/12/11 and the	K0070	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.The heating feature for the mock fire places which were cited as space heaters were disabled so that the mock fire places are solely for aesthetic purposes.II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.All residents had the potential to be affected by the alleged deficient practice. The heating feature for the mock fire places which were cited as space heaters were disabled so that the mock fire places are solely for aesthetic purposes.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.Staff was educated regarding facilitiy rules of not using space heaters and what constitutes a space heater.IV. How the corrective action(s) will	01/11/2012

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	administrator stated the facility did not have a written policy in place for the use of portable space heating devices. 3.1-19(b)		be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.Facility rules regarding space heaters has been added to the new hiring packet and will be part of the normal staff curriculum for 1 year.	
K0074 SS=E	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 Based on observation and interview, the facility failed to ensure 10 of 45 sprinklered resident rooms were provided with 18 inches of clearance from the ceiling to the bottom of the cubicle curtain mesh for sprinklers to be effective. NFPA 13, Table 4-6.5.1.2 requires the distance above an obstruction for pendant or upright sprinklers to be 18	K0074	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.Resident room privacy curtains that did not meet code and allow the 18 inches of clearance were removed and disposed of then replaced with curtains that did meet current code.II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.Any	01/11/2012

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	inches if the obstruction is five feet or more from the sprinkler. This deficient practice affects 20 residents in rooms 101, 103, 104, 105, 106. 107, 108, 109, 110, and 209. Findings include: Based on observations on 12/12/11 during a tour of the facility from 9:10 a.m. to 1:40 p.m. with the maintenance supervisor, the following sprinklered resident rooms had cubicle curtains with less than 1/2 inch diameter holes: 101, 103, 104, 105, 106, 107, 108, 109, 110, and 209. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the 1:45 p.m. exit conference on 12/12/11. 3.1-19(b)		resident residing in this facility had the potential to be affected but were not harmed by the alleged deficient practice. Curtains were inspected to be certain that each resident room privacy curtain met current code.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.The resident room privacy curtains and inventoried curtains were inspected for compliance with current code. All curtains that did not meet current code were disposed of so that they could not be put back into circulation and the alleged deficient practice could not recur.IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.The resident room privacy curtains and inventoried curtains were inspected for compliance with current code. All curtains that did not meet current code were disposed of so that they could not be put back into circulation and the alleged deficient practice could not recur. All replacement curtains purchased will be inspected by Maintenance Supervisor or designee prior to distribution to resident rooms.	

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K0075 SS=E	Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 Based on observation and interview, the facility failed to ensure soiled linen containers in 1 of 7 corridors did not exceed 32 gallons. This deficient practice could affect 30 resident who reside on the 400 Hall. Findings include: Based on observation on 12/12/11 at 12:15 p.m. with the maintenance supervisor, the 400 West Hall near the dining room had one ninety six gallon plastic trash container stored in the corridor next to the 400 West Hall exit door. The receptacle size was verified on the bottom of the receptacle and verified by the maintenance supervisor at the time of observation. This was confirmed by the administrator at the 1:45 p.m. exit conference on 12/12/11.	K0075	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.The 96 gallon trash container and soiled linen container was relocated to a storeage room with a self-closing device.II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.Residents residing on the 400 hall where the alleged deficient practice was alleged to have occured were identified as having the potential to be affected. The 96 gallon container and soiled linen container was relocated to a storeage room with a self-closing device.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.Staff was educated on the regulations regarding proper storeage of soiled linen and trash collection receptacles.IV. How the corrective action(s) will be monitored to ensure the deficient	01/11/2012

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	3.1-19(b)		practice will not recur, i.e., what quality assurance program will be put into place.The monitoring of proper storeage of soiled linen and trash collection receptacles was added to the preventative maintenance logs to be monitored weekly for 4 weeks, monthly for 2 months, and quarterly for 1 quarter.	
K0144 SS=E	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators were provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a	K0144	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.The Maintenance Supervisor was unaware of the remote annunciator for the generator. This is located across the hall from the 400 hall nurses station and is in clear line of sight of the nurses station. There is now written record of weekly inspections including but not limited to monthly load tests, weekly exercises, and battery tests for the generator in accordance with NFPA 99 and 110 as required by Life Safety Code.II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.All residents were identified as being potentially affected by the alleged deficient practice but not harmed. The Maintenance Supervisor was unaware of the	01/11/2012

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	common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all the residents as well as visitors and staff. Findings include: Based on observation on 12/12/11 during a tour of the facility from 9:10 a.m. to 1:40 p.m. with the maintenance supervisor, there was no remote alarm annunciator for the emergency generator in a location readily observed by operating personnel at a regular work station such as a nurses' station. Furthermore, the only remote alarm		remote annunciator for the generator. This is located across the hall from the 400 hall nurses station and is in clear line of sight of the nurses station. There is now written record of weekly inspections including but not limited to monthly load tests, weekly exercises, and battery tests for the generator in accordance with NFPA 99 and 110 as required by Life Safety Code.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.A Maintenance Supervisor designee has been assigned and trained to perform the daily, weekly, and monthly tasks that the Maintenance Supervisor must complete to stay in compliance with Life Safety Code so that regulatory requirements are not missed or undocumented in the future.IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.The documentation associated with the generator will be overseen by the Executive Director or designee for monthly for 3 months and quarterly for 3 quarters.	

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	annunciator for the generator was located on the outside generator location, outside the 400 West Hall exit. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the 1:45 p.m. exit conference on 12/12/11. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 13 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. 6-4.1 requires Level 1 and Level 2 EPSS, including all appurtenant components, shall be inspected weekly and shall be exercised under load monthly at a minimum. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly			

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	maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the maintenance supervisor on 12/12/11 at 9:10 a.m., there was no record of weekly storage battery tests and weekly inspections of the generator set for the last week of March 2011, and the months of June, July, and August 2011. Additionally, per interview during the record review, the maintenance supervisor stated there was no other documentation available for review to verify these weekly generator inspections were conducted. This was confirmed by the administrator at the 1:45 p.m. exit conference on 12/12/11. 3.1-19(b) 3. Based on record review and interview for 3 of 12 months, the facility failed to exercise the generator to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to			

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	conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors. Findings include: Based on interview and review of the Emergency Generator Load Testing Log with the maintenance supervisor on 12/12/11 at 9:10 a.m., there was no record of a monthly load test for the months of June, July and August of 2011. Additionally, per interview during the record review, the maintenance supervisor stated there was no other documentation			

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	available for review to verify these monthly load tests on the generator were conducted. This was confirmed by the administrator at the 1:45 p.m. exit conference on 12/12/11. 3.1-19(b)			
K0147 SS=E	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 5 of 38 wet location resident care areas were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas that are subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 30 residents who reside on the 400 Hall, and 18 residents who reside on the 300 Hall as well as staff.	K0147	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.The outlets requiring GFCI protection were repaired and GFCI was installed.II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.Residents residing on halls where an outlet in a wet location exists without GFCI protection were identified as being potentially affected by the alleged deficient practice. The outlets requiring GFCI protection were repaired and GFCI was installed.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.Staff was educated regarding Life Safety Code and the rules associated with receptacles in wet locations.IV. How the corrective action(s) will be monitored to ensure the deficient practice will	01/11/2012

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	Findings include: Based on observations with the maintenance supervisor during a tour of the facility from 9:10 a.m. to 1:40 p.m. on 12/12/11, an electric receptacle was on the wall within three feet of the handwash sink in the 400 Hall pantry, the 400 West Hall medication room, the 400 West Hall dining room pantry, the 300 Hall nurses' station, and the 400 Hall nutrition pantry by the smoke barrier doors. Based on interview and testing with the Maintenance Supervisor at the time of observation, neither the electrical outlets nor the circuit breakers for these outlets were provided with GFCI protection. The lack of GFCI protection in the electric receptacles near the handwash sinks in these areas was confirmed by the administrator at the 1:45 p.m. exit conference on 12/12/11. 3.1-19(b)		not recur, i.e., what quality assurance program will be put into place.The Maintenance Supervisor or designee will monitor wet locations and receptacles monthly for 3 months on the preventative maintenance log to assure compliance with Life Safety Code.	